

Nevada State Board of Pharmacy
431 W Plumb Lane . Reno, NV 89509 . 775-850-1440
bop.nv.gov

**OUT-OF-STATE
(For locations shipping to the State of Nevada
PHARMACY APPLICATION
INFORMATION AND CHECKLIST**

**This application cannot be returned by fax or email.
We must have an original signature and fee to process.**

Failure to submit a complete application will result in significant delays in the processing of the application and issuance of the license.

Please understand we cannot and will not accept incomplete applications. Review the checklist and return all required fees and documentation with the completed application.

Submission of the application just prior to the deadline date does not guarantee placement on the board agenda. .

Please note the application/documentation deadline date is on the board meeting schedule listed on the website. The deadline date is the LAST DAY completed applications will be accepted for that particular board meeting. If the application and all pertaining documentation is not complete and enclosed, the application will be returned.

For a location or name change of an out-of-state pharmacy, we only require notification in writing. A new application is only required if changing ownership of 50% or greater..

REQUIRED DOCUMENTS FOR ALL TYPES OF OWNERSHIP

You will also be required to submit additional information depending on your ownership type. Details regarding the additional information are included with the application.

Complete all required pages of the application. Must be original signature(s), no copies or stamps.

Statement of Responsibility. This is page 7 included with the application

Certificate of Corporate status (also referred to as Certificate of Good Standing). The Certificate of Corporate status is obtained from the Secretary of State's office in the State where incorporated. This Certificate of Corporate status must be dated within the last 6 months.

Registration fee of \$500.00. This fee is non-refundable and non-transferable. The fee is payable by money order or cashier's check only, we do not accept personal checks, business checks, cash or credit cards. If the application is received with a personal, business check or cash, it will be returned and will delay the processing of the application. **Fee made payable to: Nevada State Board of Pharmacy**

Letter of good standing from the state or regulatory board in which your company is located. Download the form from the website under the ~~New Applications~~+tab. The forms are available under the *documents for all types of businesses*. An original separate letter from the state or regulatory board also acceptable.

Copy of current registration or license for the pharmacy in the state of residence.

Addendum to Pharmacy Application . Internet. This addendum is required if you will be providing internet services. Download the form from the website under the ~~New Applications~~+tab. The forms are available under the *documents for all types of businesses*.

Copy of Current DEA Registration (if applicable)

REQUIRED INFORMATION FOR ALL TYPES OF OWNERSHIP

An application for an out-of-state pharmacy requires Board approval. Upon receipt of the completed application, documentation and fee, your application will be placed on the agenda of the next regularly scheduled Board meeting. The current board meeting schedule is available on the website under the ~~Calendar of Upcoming Boards & Committee Meetings~~+

AN APPEARANCE AT THE BOARD MEETING WILL BE REQUIRED, IF THE PHARMACY INTENDS TO SHIP PARENTERAL PRODUCTS INTO NEVADA. Nevada Administrative Code (NAC) 639.215 provides, ~~An~~ applicant for a license to operate a pharmacy in the State of Nevada must appear before the board in support of the application and must received instructions relative to the pharmacy laws, if the applicant . . . (c) is applying for the licensure of a pharmacy located outside the state that will be shipping compounded parenteral products into this state.

The purpose is to insure firms will provide a continuum of home parenteral care which has frequently been absent with contract providers of parenteral pharmaceutical products from out-of-state. Our regulation in part will require:

1. A pharmacist, practitioner and nurse must be available at all times for immediate assistance to the patient;
2. The pharmacy must have access to orders for the medication, laboratory tests and other patient treatments; and
3. Documentation that patient assessment has been performed.

Your presence before the board can describe how these services are available and how you fulfill the requirements of the regulations.

The board has a legal right to require an appearance at a schedule board meeting. If an appearance is **required**, your company will be notified in writing two (2) weeks prior to the meeting.

If you check off-site cognitive services on the application, Nevada Administrative Code 639.4916 requires ~~%A~~ a pharmacist who is employed by an off-site pharmaceutical service provide t o provide remote chart order processing services to a hospital or correctional institution pursuant to NAC 639.4915 must (a) Be licensed to practice in Nevada.+ Provide name and Nevada pharmacist license number.

A license is usually issued and mailed within 10 days from the board meeting date, if approved.

This license is renewed in October of even numbered years, no matter when the license is issued. Fees are not pro-rated.

Please access the applicable laws on the website under ~~%Nevada Statues & Regulations~~+tab.

If you have any questions, contact the licensing specialist in the Reno office at (775) 850-1440 or by email at pharmacy@pharmacy.nv.gov.

NEVADA STATE BOARD OF PHARMACY

431 W Plumb Lane . Reno, NV 89509 . (775) 850-1440

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

\$500.00 Fee made payable to: Nevada State Board of Pharmacy

(non-refundable and not transferable money order or cashier's check only)

Application must be printed legibly or typed

Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

- | | |
|--|--|
| <input type="checkbox"/> New Pharmacy | <input type="checkbox"/> Ownership Change |
| (Please provide current license number if making changes: PH_____) | |
| <input type="checkbox"/> Publicly Traded Corporation . Pages 1,2,3,7 | <input type="checkbox"/> Partnership - Pages 1,2,5,7 |
| <input type="checkbox"/> Non Publicly Traded Corporation . Pages 1,2,4,7 | <input type="checkbox"/> Sole Owner . Pages 1,2,6,7 |
| Please check box for type of ownership and complete correct part of the application. | |

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: _____

Physical Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

Toll Free Number: _____ (Required per NAC 639.708)

E-mail: _____ Website: _____

Managing Pharmacist: _____ License Number: _____

Hours of Operation:

Monday thru Friday _____am _____pm

Saturday _____am _____pm

Sunday _____am _____pm

24 Hours _____

TYPE OF PHARMACY

SERVICES PROVIDED

- | | |
|--|--|
| <input type="checkbox"/> Retail | <input type="checkbox"/> Off-site Cognitive Services |
| <input type="checkbox"/> Hospital (# beds _____) | <input type="checkbox"/> Parenteral |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Parenteral (outpatient) |
| <input type="checkbox"/> Nuclear | <input type="checkbox"/> Outpatient/Discharge |
| <input type="checkbox"/> Out of State | <input type="checkbox"/> Mail Service |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Long Term Care |

APPLICATION FOR OUT-OFSTATE PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

- 1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)? Yes ☐ No ☐
- 2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration? Yes ☐ No ☐
- 3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action or proceeding relating to the pharmaceutical industry? Yes ☐ No ☐
- 4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances? Yes ☐ No ☐
- 5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)? Yes ☐ No ☐

If the answer to question 1 through 5 is ~~yes~~, a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Print Name of Authorized Person

Date

Board Use Only

Received: _____

Amount: _____

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: _____

Parent Company if any: _____

Corporation Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Contact Person: _____

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: _____

Registration number issued: _____

Stock Exchange: _____

Include with the application for a publicly traded corporation

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors.

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: _____

Parent Company if any: _____

Corporation Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Contact Person: _____

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?

a) _____
Name Address

b) _____
Name Address

c) _____
Name Address

d) _____
Name Address

2) Provide the number of shares issued by the corporation. _____

3) What was the price paid per share? _____

4) What date did the corporation actually receive the cash assets? _____

5) Provide a copy of the corporation's stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Include with the application for a non publicly traded corporation

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP

General _____

Limited _____

Partnership Name: _____

Mailing Address: _____

City, State Zip Code: _____

Telephone Number: _____ Fax Number: _____

Contact Person: _____

List each partner and identify whether (G)eneral or (L)imited partner and percentage of ownership
Use separate sheet if necessary

<u>Name</u>	<u>G or L</u>	<u>Percentage</u>
_____	_____	_____
_____	_____	_____

List names of 4 largest partners and percentage of ownership:

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

APPLICATION FOR OUT-OF-STATE PHARMACY LICENSE

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.

Owner's Name: _____

Business Name: _____

Current Business Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

List any physician shareholders and percentage of ownership.

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

Name: _____ %: _____

CORPORATE STATEMENT OF RESPONSIBILITY
FOR PHARMACIES LOCATED OUTSIDE OF NEVADA

I, _____

Responsible Person of _____

hereby acknowledge and understand that in addition to the corporation's, any owner(s), shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation's, any owner(s), shareholder(s) or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Print Name of Authorized Person

Date